

**STATEMENT OF MANAGERS FOR THE
MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT
AND PROTECTION ACT OF 2000**

**TITLE II - RURAL HEALTH CARE IMPROVEMENTS
SUBTITLE A - CRITICAL ACCESS HOSPITAL PROVISIONS**

**Section 201. Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests
Furnished by Critical Access Hospitals**

Effective for services furnished on or after the enactment of BBRA99, Medicare beneficiaries would not be liable for any coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital (CAH) service. Conforming changes that clarify that CAHs are reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services are also included.

Section 202. Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate

Effective for items and services furnished on or after July 1, 2001, Medicare would pay a CAH for outpatient services based on reasonable costs or, at the election of an entity, would pay the CAH a facility fee based on reasonable costs plus an amount based on 115% of Medicare's fee schedule for professional services.

Section 203. Exemption of Critical Access Hospital Swing Beds from SNF PPS

Swing beds in critical access hospitals (CAHs) would be exempt from the SNF prospective payment system. CAHs would be paid for covered SNF services on a reasonable cost basis.

Section 204. Payment in Critical Access Hospitals for Emergency Room On-Call Physicians

When determining the allowable, reasonable cost of outpatient CAH services, the Secretary would recognize amounts for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility. The Secretary would define the reasonable payment amounts and the meaning of the term "on-call." The provision would be effective for cost reporting periods beginning on or after October 1, 2001.

Section 205. Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals

Ambulance services provided by a critical access hospital (CAH) or provided by an entity that is owned or operated by a CAH would be paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH. The provision would be effective for services furnished on or after enactment.

Section 206. GAO Study on Certain Eligibility Requirements For Critical Access Hospitals

Within one year of enactment, GAO would be required to conduct a study on the eligibility requirements for critical access hospitals (CAHs) with respect to limitations on average length of stay and number of beds, including an analysis of the feasibility of having a distinct part unit as part of a CAH and the effect of seasonal variations in CAH eligibility requirements. GAO also would be required to analyze the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limits on average annual length of stay and number of beds.

SUBTITLE B - OTHER RURAL HOSPITALS PROVISIONS

Section 211. Treatment of Rural Disproportionate Share Hospitals

For discharges occurring on or after April 1, 2001, all hospitals would be eligible to receive DSH payments when their DSH percentage (threshold amount) exceeds 15%. The DSH payment formulas for sole community hospitals (SCHs), rural referral centers (RRCs), rural hospitals that are both SCHs and RRCs, small rural hospitals and urban hospitals with less than 100 beds would be modified.

Section 212. Option to Base Eligibility for Medicare Dependent, Small Rural Hospital Program on Discharges During 2 of the 3 Most Recent Audited Cost Reporting Periods

An otherwise qualifying small rural hospital would be able to be classified as an MDH if at least 60% of its days or discharges were attributable to Medicare Part A beneficiaries in at least two of the three most recent audited cost reporting periods for which the Secretary has a settled cost report.

Section 213. Extension of Option to Use Rebased Target Amounts to All Sole Community Hospitals

Any SCH would be able to elect payment based on hospital specific, updated FY1996 costs if this target amount resulted in higher Medicare payments. There would be a transition period with Medicare payment based completely on updated FY1996 hospital specific costs for discharges occurring after FY2003.

Section 214. MedPAC Analysis of Impact of Volume on Per Unit Cost of Rural Hospitals with Psychiatric Units

MedPAC would be required to report on the impact of volume on the per unit cost of rural hospitals with psychiatric units and include in its report a recommendation on whether special treatment is warranted.

SUBTITLE C - OTHER RURAL PROVISIONS

Section 221. Assistance for Providers of Ambulance Services in Rural Areas

The provision would make additional payments to providers of ground ambulance services for trips, originating in rural areas, that are greater than 17 miles and up to 50 miles. The payments would be made for services furnished on or after July 1, 2001 and before January 1, 2004. The provision would require the Comptroller General to conduct a study to examine both the costs of efficiently providing ambulance services for trips originating in rural areas and the means by which rural areas with low population densities can be identified for the purpose of designating areas in which the costs of ambulance services would be expected to be higher. The Comptroller General would submit a report to Congress by June 30, 2002 on the results of the study, together with recommendations on steps that should be taken to assure access to ambulance services for trips originating in rural areas. The Secretary would be required to take these findings into account when establishing the fee schedule, beginning with 2004.

Section 222. Payment for Certain Physician Assistant Services

This provision would give permanent authority to physician assistants who owned rural health clinics that lost their designation as such to bill Medicare directly.

Section 223. Expansion of Medicare Payment for Telehealth Services

The provision would establish revised payment provisions, effective no later than October 1, 2001, for services that are provided via a telecommunications system by a physician or practitioner to an eligible beneficiary

in a rural area. The Secretary would be required to make payments for telehealth services to the physician or practitioner at the distant site in an amount equal to the amount that would have been paid to such physician or practitioner if the service had been furnished to the beneficiary without the use of a telecommunications system. A facility fee would be paid to the originating site. Originating sites would include a physician or practitioner office, a critical access hospital, a rural health clinic, a Federally qualified health center or a hospital. The Secretary would be required to conduct a study, and submit recommendations to Congress, that identify additional settings, sites, practitioners and geographic areas that would be appropriate for telehealth services. Entities participating in Federal demonstration projects approved by, or receiving funding from, the Secretary as of December 31, 2000 would be qualified sites.

Section 224. Expanding Access to Rural Health Clinics

All hospitals of less than 50 beds that own rural health clinics would be exempt from the per visit limit.

Section 225. MedPAC Study on Low-Volume, Isolated Rural Health Providers

MedPAC would be required to study the effect of low patient and procedure volume on the financial status and Medicare payment methods for hospital outpatient services, ambulance services, hospital inpatient services, skilled nursing facility services, and home health services in isolated rural health care providers.

TITLE III - PROVISIONS RELATING TO PART A

SUBTITLE A - INPATIENT HOSPITAL SERVICES

Section 301. Revision of Acute Care Hospital Payment Update for 2001

All hospitals would receive the full market basket index (MBI) as an update for FY2001. In order to implement this increase for hospitals other than sole community hospitals (SCH), those hospitals would receive the MBI minus 1.1 percentage points (the current statutory provision) for discharges occurring on or after October 1, 2000 and before April 1 2001; these non-SCH hospitals would receive the MBI plus 1.1 percentage points for discharges occurring on or after April 1, 2001 and before October 1, 2001. As indicated by section 547(a), this payment increase would not apply to discharges occurring after FY2001. For FY2002 and FY2003, hospitals would receive the MBI minus .55 percentage points. For FY2004 and subsequently, hospitals would receive the MBI.

The Secretary is directed to consider the prices of blood and blood products purchased by hospitals in the next rebasing and revision of the hospital market basket to determine whether those prices are adequately reflected in the market basket index. MedPAC is directed to conduct a study on increased hospital costs attributable to complying with new blood safety measures and providing such services using new technologies among other issues.

For discharges occurring on or after October 1, 2001, the Secretary would be able to adjust the standardized amount in future fiscal years to correct for changes in the aggregate Medicare payments caused by adjustments to the DRG weighting factors in a previous fiscal year (or estimates that such adjustments for a future fiscal year) that did not take into account coding improvements or changes in discharge classifications and did not accurately represent increases in the resource intensity of patients treated by PPS hospitals.

Section 302. Additional Modification in Transition for Indirect Medical Education (IME) Percentage Adjustment

Teaching hospitals would receive 6.25% IME payment adjustment (for each 10% increase in teaching intensity) for discharges occurring on or after October 1, 2000 and before April 1, 2001. The IME adjustment would increase to 6.75% for discharges on or after April 1, 2001 and before October 1, 2001. As indicated in Section

547(a), the payment increase would not apply to discharges after FY2001. The HME adjustment would be 0.5% in FY2002 and 5.5% in FY2003 and in subsequent years.

Section 303. Decrease in Reductions for Disproportionate Share Hospital (DSH) Payments

Reductions in the DSH payment formula amounts would be 2% in FY2001, 3% in FY2002, and 0% in FY2003 and subsequently. To implement the FY2001 provision, DSH amounts for discharges occurring on or after October 1, 2000 and before April 1, 2001, would be reduced by 3% which was the reduction in effect prior to enactment of this provision. DSH amounts for discharges occurring on or after April 1, 2001 and before October 1, 2001 would be reduced by only 1 percentage point. As indicated by Section 547(a), this payment adjustment would not apply to discharges after FY2001.

Section 304. Wage Index Improvements

For FY2001 or any fiscal year thereafter, a Medicare Geographic Classification Review Board (MGCRB) decision to reclassify a prospective payment system hospital for use of a different area's wage index would be effective for 3 fiscal years. The Secretary would establish procedures whereby a hospital could elect to terminate this reclassification decision before the end of such period. For FY2003 and subsequently, MGCRB would base any comparison of the average hourly wage of the hospital with the average hourly wage for hospitals in the area using data from the each of the two immediately preceding surveys as well as data from the most recently published hospital wage survey.

The Secretary would establish a process which would first be available for discharges occurring on or after October 1, 2001 where a single wage index would be computed for all geographic areas in the state. If the Secretary applies a statewide geographic index, an application by an individual hospital would not be considered. The Secretary would also collect occupational data every three years in order to construct an occupational mix adjustment for the hospital area wage index. The first complete data collection effort would occur no later than September 30, 2003 for application beginning October 1, 2004.

Section 305. Payment for Inpatient Services in Rehabilitation Hospitals

Total payments for rehabilitation hospitals in FY2002 would equal the amounts of payments that would have been made if the rehabilitation prospective payment system (PPS) had not been enacted. A rehabilitation facility would be able to make a one-time election before the start of the PPS to be paid based on a fully phased-in PPS rate.

Section 306. Payment for Inpatient Services of Psychiatric Hospitals

The provision would increase the incentive payments for psychiatric hospitals and distinct part units to 3% for cost reporting periods beginning on or after October 1, 2000.

Section 307. Payment for Inpatient Services of Long-Term Care Hospitals

For cost reporting periods beginning during FY2001, long term hospitals would have the national cap increased by 2% and the target amount increased by 25%. Neither these payments nor the increased bonus payments provided by BBRA 99 would be factored into the development of the prospective payment system (PPS) for long term hospitals. When developing the PPS for inpatient long term hospitals, the Secretary would be required to examine the feasibility and impact of basing payment on the existing (or refined) acute hospital DRGs and using the most recently available hospital discharge data. If the Secretary is unable to implement a long term hospital PPS by October 1, 2002, the Secretary would be required to implement a PPS for these hospitals using the existing acute hospital DRGs that have been modified where feasible.

Section 311. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001

The provision would modify the schedule and rates according to which federal per diem payments are updated. In FY2002 and FY2003 the updates would be the market basket index increase minus 0.5 percentage point. The update rate for the period October 1, 2000, through March 31, 2001, would be the market basket index increase minus 1 percentage point; the update rate for the period April 1, 2001, through September 30, 2001, would be the market basket index increase plus one percentage point (this increase would not be included when determining payment rates for the subsequent period). Temporary increases in the federal per diem rates provided by BBRA 99 would be in addition to the increases in this provision. By July 1, 2002, the Comptroller General would be required to submit a report to Congress on the adequacy of Medicare payments to SNFs, taking into account the role of private payers, medicaid, and case mix on the financial performance of SNFs and including an analysis, by RUG classification, of the number and characteristics of such facilities. By January 1, 2005, the Secretary would be required to submit a report to Congress on alternatives for classification of SNF patients.

Section 312. Increase in Nursing Component of PPS Federal Rate

The provision would increase the nursing component of each RUG by 16.66 percent over current law for SNF care furnished after April 1, 2001, and before October 1, 2002.

The Comptroller General would be required to conduct an audit of nurse staffing ratios in a sample of SNFs and to report to Congress by August 1, 2002, on the results of the audit of nurse staffing ratios and recommend whether the additional 16.66 percent payment should be continued.

Section 313. Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays

Effective January 1, 2001, the provision would limit the current law consolidated billing requirement to services and items furnished to SNF residents in a Medicare part A covered stay and to therapy services furnished in part A and part B covered stays.

The Inspector General of HHS would be required to monitor part B payments to SNFs on behalf of residents who are not in a part A covered stay.

Section 314. Adjustment of Rehabilitation RUGS to Correct Anomaly in Payment Rates

Effective for skilled nursing facility (SNF) services furnished on or after April 1, 2002, the provision would increase by 6.7 percent certain federal per diem payments to ensure that Medicare payments for SNF residents with “ultra high” and “high” rehabilitation therapy needs are appropriate in relation to payments for residents needing “medium” or “low” levels of therapy. The 20 percent additional payment that was provided in BBRA 99 for certain RUGS is removed to make this provision budget neutral.

The Inspector General of HHS would be required to review and report to Congress by October 1, 2001, regarding whether the RUG payment structure as in effect under the BBRA 99 includes incentives for the delivery of inadequate care.

Section 315. Establishment of Process for Geographic Reclassification

The provision would permit the Secretary to establish a process for geographic reclassification of skilled nursing facilities based upon the method used for inpatient hospitals. The Secretary may implement the process

upon completion of the data collection necessary to calculate an area wage index for workers in skilled nursing facilities.

SUBTITLE C - HOSPICE CARE

Section 321. 5 Percent Increase in Payment Base

The provision would increase, effective April 1, 2001, the base Medicare daily payment rates for hospice care for fiscal year 2001 by 5 percentage points over the rates otherwise in effect. This increase would continue to apply after fiscal year 2001. The temporary increase in payment rates provided in BBRA 99 for FY2001 and FY2002 (.5 percent and .75 percent, respectively) would not be affected. In addition, the hospice wage index for one Metropolitan Statistical Area for fiscal year 2000 would be adjusted.

Section 322. Clarification of Physician Certification

Effective for certifications of terminal illness made on or after the date of enactment, the provision would modify current law to specify that the physician's or hospice medical director's certification of terminal illness would be based on his/her clinical judgment regarding the normal course of the individual's illness. The Secretary would be required to study and report to Congress within 2 years of enactment on the appropriateness of certification of terminally ill individuals and the effect of this provision on such certification.

Section 323. MedPAC Report on Access to, and Use of, Hospice Benefit

The provision would require MedPAC to examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences in utilization rates. The provision would require a report on the study to be submitted to Congress 18 months after enactment.

SUBTITLE D - OTHER PROVISIONS

Section 331. Relief From Medicare Part A Late Enrollment Penalty For Group Buy-In for State and Local Retirees

The provision would exempt certain state and local retirees, retiring prior to January 1, 2002, from the Part A delayed enrollment penalties. These would be groups of persons for whom the state or local government elected to pay the delayed Part A enrollment penalty for life. The amount of the delayed enrollment penalty which would otherwise be assessed would be reduced by an amount equal to the total amount of Medicare payroll taxes paid by the employee and the employer on behalf of the employee. The provision would apply to premiums for months beginning with January 1, 2002.

TITLE IV - PROVISIONS RELATING TO PART B

SUBTITLE A - HOSPITAL OUTPATIENT SERVICES

Section 401. Revision of Hospital Outpatient PPS Payment Update

The provision would modify the current law update rates applicable to the hospital outpatient PPS by providing in FY2001 an update equal to the full rate of increase in the market basket index. As under current law, the increase in FY2002 would be the market basket index increase minus one percentage point.

A special rule applies to the OPD PPS rates in 2001. For the period January 2, 2001 through March 31, 2001, the PPS amounts shall be those in effect on the day before implementation of the new law. For the periods April 1, 2001, through December 31, 2001, the PPS amounts in effect during the prior period shall be increased by 0.32%.

Effective as if enacted with BBA 97, if the Secretary determines that updates to the adjustment factor used to convert the relative utilization weights under the PPS into payment amounts have, or are likely to, result in hospitals' changing their coding or classification of covered services, thereby changing aggregate payments, the Secretary would be authorized to adjust the conversion factor in later years to eliminate the effect of coding or classification changes.

Section 402. Clarifying Process and Standards for Determining Eligibility of Devices for Pass-through Payments under Hospital Outpatient PPS

The provision would modify the procedures and standards by which certain medical devices are categorized and determined eligible for pass-through payments under the PPS. Through public rule-making procedures, the Secretary would be required to establish criteria for defining special payment categories under the PPS for new medical devices. The Secretary would be required to promulgate, through the use of a program memorandum, initial categories that would encompass each of the individual devices that the Secretary had designated as qualifying for the pass-through payments to date. In addition, similar devices not so designated because they were payable under Medicare prior to December 31, 1996, would also be included in initial categories. The Secretary would be required to create additional new categories in the future to accommodate new technologies meeting the "not insignificant cost" test established in BBRA 99.

Once the categories were established, pass-through payments currently authorized under section 1833(t)(b) of the Social Security Act would proceed on a category-specific, rather than device-specific basis. These payments would be designated as "category-based pass-through payments." These payments would be continued to be made for the 2 to 3 years payment period originally specified in BBRA 99, and, for each given category, would begin when the first such payment is made for any device included in a specified category. At the conclusion of this transitional payment period, categories would sunset and payment for the device would be included in the underlying PPS payment for the related service.

Section 403. Application of OPD PPS Transitional Corridor Payments to Certain Hospitals That Did Not Submit a 1996 Cost Report

Effective as if enacted with BBRA 99, the provision would modify current law as enacted in BBA 99 to enable all hospitals, not just those hospitals filing 1996 cost reports, to be eligible for transitional payments under the PPS.

Section 404. Application of Rules for Determining Provider-based Status for Certain Entities

The provision would grandfather existing arrangements whereby certain entities (such as outpatient clinics, skilled nursing facilities, etc.) are considered "provider-based" entities, meaning they are affiliated financially and clinically with a main hospital. Existing provider-based status designations would continue for two years beginning October 1, 2000. If a facility or organization requests approval for provider-based status during the period October 1, 2000, through September 31, 2002, it could not be treated as if it did not have such status during the period of time the determination is pending. In making such a status determination on or after October 1, 2000, HCFA would treat the applicant as satisfying any requirements or standards for geographic location if it satisfied geographic location requirements in regulations or is located not more than 35 miles from the main campus of the hospital.

An applicant facility or organization would be treated as satisfying all requirements for provider-based status if it is owned or operated by a unit of State or local government or is a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or is a private hospital that, under contract, serves certain low income households or has a certain disproportionate share adjustment.

These provisions are in effect during a two-year period beginning on October 1, 2000.

Section 405. Treatment of Children's Hospitals under Prospective Payment System

The BBRA 99 provides special "hold harmless" payments to ensure that cancer hospitals would receive no less under the hospital outpatient PPS than they would have received, in aggregate, under the "pre-BBA" system, that is, the pre-PPS payment system. Effective as if included in the BBRA 99, the provision would extend this hold harmless protection to children's hospitals.

Section 406. Inclusion of Temperature Monitored Cryoablation

The provision would include temperature monitored cryoablation as part of the transitional pass-through for certain medical devices, drugs, and biologicals under the hospital outpatient prospective payment system, effective April 1, 2001.

SUBTITLE B - PROVISIONS RELATING TO PHYSICIANS SERVICES

Section 411. GAO Studies Relating to Physicians' Services

The provision would require the GAO to conduct a study on the appropriateness of furnishing in physicians offices specialist services (such as gastrointestinal endoscopic physicians services) which are ordinarily furnished in hospital outpatient departments. The GAO would also be required to study the refinements to the practice expense relative value units made during the transition to the resource-based system.

Section 412. Physician Group Practice Demonstration

The provision would require the Secretary to conduct demonstration projects to test, and if proven effective, expand the use of incentives to health care groups participating under Medicare. Such incentives would be designed to encourage coordination of care furnished under Medicare Parts A and B by institutional and other providers and practitioners; to encourage investment in administrative structures and processes to encourage efficient service delivery; and to reward physicians for improving health outcomes. The Secretary would establish for each group participating in a demonstration, a base expenditure amount and an expenditure target (reflecting base expenditures adjusted for risk and expected growth rates). The Secretary would pay each group a bonus for each year equal to a portion of the savings for the year relative to the target. In addition, at such time as the Secretary had developed appropriate criteria, the Secretary would pay an additional bonus related to process and outcome improvements. Total payments under demonstrations could not exceed what the Secretary estimates would be paid in the absence of the demonstration program.

Section 413. Study on Enrollment Procedures for Groups That Retain Independent Contractor Physicians

The provision would require the Comptroller General to conduct a study of the current Medicare enrollment process for groups that retain independent contractor physicians; particular emphasis would be placed on hospital-based physicians, such as emergency department staffing groups.

SUBTITLE C - OTHER SERVICES

Section 421. One-Year Extension of Moratorium on Therapy Caps; Report on Standards for Supervision of Physical Therapy Assistants

The provision would extend the moratorium on the physical therapy and occupational therapy caps for 1 year through 2002; it would also extend the requirement for focused reviews of therapy claims for the same period. The Secretary would be required to conduct a study on the implications of eliminating the "in the room" supervision

requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists and the implications of this requirement on the physical therapy cap.

Section 422. Update in Renal Dialysis Composite Rate

The provision would specify that the composite rate payment for renal dialysis services would be increased by 2.4% for 2001. The provision would require the Secretary to collect data and develop an end-stage renal disease (ESRD) market basket whereby the Secretary could estimate before the beginning of a year the percentage increase in costs for the mix of labor and non-labor goods and services included in the composite rate. The Secretary would report to Congress on the index together with recommendations on the appropriateness of an annual or periodic update mechanism for dialysis services. The Comptroller General would be required to study the access of beneficiaries to dialysis services. There is a hold harmless provision for facilities who received exceptions for their 2000 rates. In addition, facilities which did not apply for an exception in 2000 would have the opportunity to apply during the first 6 months of 2001. Exceptions granted under the hold harmless or granted during the extension period, would continue to apply so long as they provide for higher payment rates. The provision would specify that for the period January 1, 2001-March 31, 2001, the applicable composite rate is the rate in effect before enactment of this provision. The rate in effect for the period April 1, 2001-December 31, 2001 is the rate established under this section increased by a transitional percentage allowance equal to 0.39 percent.

Section 423. Payment for Ambulance Services

The provision would provide for the full inflation update in ambulance payments for 2001. It would also specify that any phase-in of the ambulance fee schedule would provide for full payment of national mileage rates in states where separate mileage payments were not made prior to implementation of the fee schedule. The provision would specify that for the period January 1, 2001-June 30, 2001, the inflation update would be that determined prior to enactment of this provision. For services furnished from July 1, 2001-December 31, 2001, the update would be 4.7%. The provision relating to mileage payments would be effective July 1, 2001.

Section 424. Ambulatory Surgical Centers

The provision would delay implementation of proposed regulatory changes to the ambulatory payment classification system, which are based on 1994 cost data, until January 1, 2002. At that time, such changes would be phased in over 4 years: in the first year the payment amounts would be 25 percent of the revised rates and 75 percent of the prior system rates; in the second year payments would be 50 percent of the revised rates and 50 percent of the prior system rates, etc. The provision also requires that the revised system, based on 1999 (or later) cost data, be implemented January 1, 2003. (The phase-in of the revised system and 1994 data would end when the system with 1999 or later data was implemented.)

Section 425. Full Update for Durable Medical Equipment

The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update would equal the full increase in the CPI-U for the 12 months ending the previous June. The provision specifies that for the period January 1, 2001, through June 30, 2000, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28%.

Section 426. Full Update for Orthotics and Prosthetics

The provision would modify updates to payments for orthotics and prosthetics. In 2000, the rates would be increased by one percent. In 2001, the increase would be equal to the percentage increase in the CPI-U during the 12-month period ending with June, 2000. For 2002, payments would be increased by one percent over the prior

year's amounts. The provision would specify that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for these items would be the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 2.6%.

Section 427. Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items

Under the provision, certain prosthetics or custom fabricated orthotics would be covered by Medicare if furnished by a qualified practitioner and fabricated by a qualified practitioner or qualified supplier. The Secretary would be required to establish a list of such items in consultation with experts. Within one year of enactment, the Secretary would be required to promulgate regulations to provide these items, using negotiated rulemaking procedures.

Not later than 6 months from enactment, the Comptroller General would be required to submit to Congress a report on the Secretary's compliance with the Administrative Procedures Act with regard to HCFA Ruling 96-1; certain impacts of that ruling; the potential for fraud and abuse in provision of prosthetics and orthotics under special payment rules and for custom fabricated items; and the effect on Medicare and Medicaid payments if that ruling were overturned.

Section 428. Replacement of Prosthetic Devices and Parts

The provision would authorize Medicare coverage for replacement of artificial limbs, or replacement parts for such devices, if ordered by a physician for specified reasons. Effective for items furnished on or after enactment, coverage would apply to prosthetic items 3 or more years old, and would supersede any 5-year age rules for such items under current law.

Section 429. Revised Part B Payment for Drugs and Biologicals and Related Services

The provision would require the Comptroller General to study and submit a report to Congress and the Secretary on the reimbursement for drugs and biologicals and for related services under Medicare; the report would include specific recommendations for revised payment methodologies. The Secretary would revise the current payment methodologies for covered drugs and biologicals and related services based on these recommendations; however, total payments under the revised methodologies could not exceed the aggregate payments the Secretary estimates would have been made under the current law. The provision would establish a moratorium on reductions in payment rates, in effect on January 1, 2001, until the Secretary reviewed the GAO report.

Section 430. Contrast Enhanced Diagnostic Procedures Under Hospital Prospective Payment System

The provision would require the Secretary to create under the hospital outpatient PPS additional and separate groups of covered services which include procedures that utilize contrast agents and would include contrast agents within the definition of "drugs" for purposes of the Medicare title. The provision would apply to items and services furnished on or after July 1, 2001.

Section 431. Qualifications for Community Mental Health Centers

The provision would clarify the qualifications for community mental health centers providing partial hospitalization services under Medicare.

Section 432. Modification of Medicare Billing Requirements for Certain Indian Providers

The provision would authorize hospitals and free-standing ambulatory care clinics of the Indian Health Service or operated by a tribe or tribal organization to bill Medicare Part B for certain services furnished at the direction of the hospital or clinic. Services covered under the provision are those furnished under the physician fee

schedule, and services furnished by a practitioner or therapist under a fee schedule. The provision would be effective July 1, 2001.

Section 433. GAO Study on Coverage of Surgical First Assisting Services of Certified Registered Nurse First Assistants

The provision would require the Comptroller General to conduct a study on the effect on both the program and beneficiaries of covering surgical first assisting services of certified registered nurse first assistants.

Section 434. MedPAC Study and Report on Medicare Reimbursement for Services Provided by Certain Providers

The provision would require MedPAC to conduct a study on the appropriateness of current payment rates for services provided by a certified nurse midwife, physician assistant, nurse practitioner, and clinical nurse specialist, including specifically for orthopedic physician assistants.

Section 435. MedPAC Study and Report on Medicare Coverage of Services Provided by Certain Non-Physician Providers

The provision would require MedPAC to conduct a study to determine the appropriateness of Medicare coverage of the services provided by a surgical technologist, marriage counselor, pastoral care counselor, and licensed professional counselor of mental health.

Section 436. GAO Study and Report on the Costs of Emergency and Medical Transportation Services

The provision would require the Comptroller General to conduct a study on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

Section 437. GAO Studies and Reports on Medicare Payments

The provision would require the Comptroller General to conduct a study on the post-payment audit process for physicians services. The study would include the proper level of resources HCFA should devote to educating physicians regarding coding and billing, documentation requirements, and calculation of overpayments. The Comptroller General would also be required to conduct a study of the aggregate effects of regulatory, audit, oversight and paperwork burdens on physicians and other health care providers participating in Medicare.

Section 438. MedPAC Study on Access to Outpatient Pain Management Services

The provision would require MedPAC to conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under Medicare.

TITLE V - PROVISION RELATING TO PARTS A AND B

SUBTITLE A - HOME HEALTH SERVICES

Section 501. 1-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits fo Home Health Services

The provision would require that the aggregate amount of Medicare payments to home health agencies in the second year of the PPS (FY2002) shall equal the aggregate payments in the first year of the PPS, updated by the market basket index (MBI) increase minus 1.1 percentage points. The 15 percent reduction to aggregate PPS amounts, which, under current law, would go into effect October 1, 2001, would be delayed until October 1, 2002.

The Comptroller General (rather than the Secretary) would be required to submit, by April 1, 2002, a report analyzing the need for the 15 percent or other reduction.

If the Secretary determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Section 502. Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001

The provision would modify the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, would apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates would be increased by 2.2 percent for 60-day episodes (or visits) ending in that time period. This increase would be included in determining subsequent payment amounts.

Section 503. Temporary Two-Month Periodic Interim Payment

The provision would provide for a one-time payment for certain home health agencies that were receiving periodic interim payments under current law. Home health agencies that were receiving such payments as of September 30, 2000, receive a one-time payment equal to four times the last 2-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts would be included in the agency's last settled cost report before implementation of the PPS.

Section 504. Use of Telehealth in Delivery of Home Health Services

The provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment.

Section 505. Study on Costs to Home Health Agencies of Purchasing Nonroutine Medical Supplies

The provision would require that, not later than August 15, 2001, the Comptroller General shall submit to Congress a report regarding the variation in prices home health agencies pay for nonroutine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary would be required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

Section 506. Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas

The provision would clarify that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary would be authorized to include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status.

Not later than January 1, 2002, the Comptroller General would be required to submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas and to make recommendations on whether national standards for supervision would be appropriate in assuring quality.

Section 507. Clarification of the Homebound Benefit

The provision clarifies that the need for adult day care for a patient's plan of treatment does not preclude appropriate coverage for home health care for other medical conditions. The provision also clarifies the ability of homebound beneficiaries to attend religious services without being disqualified from receiving home health benefits.

Section 508. Temporary Increase for Home Health Services Furnished in a Rural Area

For home health services furnished in certain rural areas during the 2-year period beginning April 1, 2001, Medicare payments are increased by 10%, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase would not be included in determining subsequent payments.

SUBTITLE B - DIRECT GRADUATE MEDICAL EDUCATION

Section 511. Increase in Floor for Direct Graduate Medical Education Payments

A hospital's approved per resident amount for cost reporting periods beginning during FY2002 would not be less than 85% of the locality adjusted national average per resident amount.

Section 512. Change in Distribution Formula for Medicare+Choice-Related Nursing and Allied Health Education Costs

A hospital would receive nursing and allied health payments for Medicare managed care enrollees based on its per day cost of allied and nursing health programs and number of days attributed to Medicare enrollees in comparison to that in all other hospitals. The provision would be effective for portions of cost reporting periods occurring on or after January 1, 2001.

SUBTITLE C - CHANGES IN MEDICARE COVERAGE AND APPEALS PROCESS

Section 521. Revisions to Medicare Appeals Process

The provision would modify the Medicare appeals process. Generally, initial determinations by the Secretary would be concluded no later than 45-days from the date the Secretary received a claim for benefits. Any individual dissatisfied with the initial determination would be entitled to a redetermination by the carrier or fiscal intermediary who made the initial determination. Such redetermination would be required to be completed within 30 days of a beneficiary's request. Beneficiaries could appeal the outcome of a redetermination by seeking a reconsideration. Generally, a request for a reconsideration must be initiated no later than 180 days after the date the individual receives the notice of an adverse redetermination. In addition, if contested amounts are greater than \$100, an individual would be able to appeal an adverse reconsideration decision by requesting a hearing by the Secretary (first for a hearing by an administrative law judge, then in certain circumstances, for a hearing before the Department Appeals Board). If the dispute is not satisfactorily resolved through this administrative process, and if contested amounts are greater than \$1,000, the individual would be able to request judicial review of the Secretary's final decision. Aggregation of claims to meet these thresholds would be permitted.

An expected determination would be available for a beneficiary who received notice: 1) that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely to place the beneficiary's health at risk; or 2) that the provider plans to discharge the beneficiary.

The Secretary would enter into 3-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations. A QIC would promptly notify beneficiaries and Medicare claims processing contractors of its determinations. A beneficiary could appeal the decision of a QIC to an ALJ. In cases where the ALJ decision is not rendered within the 90-day deadline, the appealing party would be able to request a DAB hearing.

The Secretary would perform outreach activities to inform beneficiaries, providers, and suppliers of their appeal rights and procedures. The Secretary would submit to Congress an annual report including information on the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including recommendations for change as necessary. The report would also contain an analysis of the consistency of the QIC determinations as well as the cause for any identified inconsistencies.

Section 522. Revisions to Medicare Coverage Process

The provision would clarify when and under what circumstances Medicare coverage policy could be challenged. An aggrieved party could file a complaint concerning a national coverage decision. Such complaint would be reviewed by the Department Appeals Board (DAB) of HHS. The provision would also permit an aggrieved party to file a complaint concerning a local coverage determination. In this case, the determination would be reviewed by an administrative law judge. If unsatisfied, complainants could subsequently seek review of such a local policy by the DAB. In both cases, a DAB decision would constitute final HHS action, and would be subject to judicial review. The Secretary would be required to implement DAB decisions and ALJ decisions (in the case of a local coverage policy) within 30 days. The provision would also permit an affected party to submit a request to the Secretary to issue a national coverage or noncoverage determination if one has not been issued. The Secretary would have 90 days to respond. HHS would be required to prepare an annual report on national coverage determinations.

SUBTITLE D - IMPROVING ACCESS TO NEW TECHNOLOGIES

Section 531. Reimbursement Improvements for New Clinical Laboratory Tests and Durable Medical Equipment

The provision would specify that the national limitation amount for a new clinical laboratory test would equal 100% of the national median for such test. The Secretary would be required to establish procedures that permit public consultation for coding and payment determinations for new clinical diagnostic laboratory tests and new durable medical equipment. The Secretary would be required to report to Congress on specific procedures used to adjust payments for advanced technologies; the report would include recommendations for legislative changes needed to assure fair and appropriate payments.

Section 532. Retention of HCPCS Level III Codes.

The provision would extend the time for the use of local codes (known as HCPCS level III codes) through December 31, 2003; the Secretary would be required to make the codes available to the public.

Section 533. Recognition of New Medical Technologies Under Medicare Inpatient Hospital PPS

The Secretary would be required to submit a report to Congress no later than April 1, 2001, on potential methods for more rapidly incorporating new medical services and technologies used in the inpatient setting in the clinical coding system used with respect to payment for inpatient services. The Secretary would be required to identify the preferred methods for expediting these coding modifications in her report, and to implement such method by October 1, 2001. Additional hospital payments could be made by means of a new technology group

(DRG), an add-on payment, payment adjustment or other mechanism. However, separate fee schedules for additional new technology payments would not be permitted. The Secretary would implement the new mechanism on a budget neutral basis. The total amount of projected additional payments under the mechanism would be limited to an amount not greater than the Secretary's annual estimation of the costs attributable to the introduction of new technology in the hospital sector as a whole (as estimated for purposes of the annual hospital update calculation).

SUBTITLE E - OTHER PROVISIONS

Section 541. Increase in Reimbursement for Bad Debt

Effective beginning with cost reports starting in FY2001, the provision would increase the percentage of the reasonable costs associated with beneficiaries' bad debt in hospitals that Medicare would reimburse to 70%.

Section 542. Treatment of Certain Physician Pathology Services Under Medicare

The provision would permit independent laboratories, under a grandfather arrangement to continue, for a 2-year period (2001-2002), direct billing for the technical component of pathology services provided to hospital inpatients and hospital outpatients. The Comptroller General would be required to conduct a study of the effect of these provisions on hospitals and laboratories and access of fee-for-service beneficiaries to the technical component of physician pathology services. The report would include recommendations on whether the provisions should continue after the 2-year period for either (or both) inpatient and outpatient hospital services and whether the provision should be extended to other hospitals.

Section 543. Extension of Advisory Opinion Authority

The Office of the Inspector General's authority to issue advisory opinions to outside parties who request guidance on the applicability of the anti-kickback statute, safe harbor provisions and other OIG health care fraud and abuse sanctions would be made permanent.

Section 544. Change in Annual MedPAC Reporting

The provision would delay the reporting date for the MedPAC report on issues affecting the Medicare program by 15 days to June 15. The provision would also require record votes on recommendations contained both in this report and the March report on payment policies.

Section 545. Development of Patient Assessment Instruments

The provision would require the Secretary to report to the Congress on the development of standard instruments for the assessment of the health and functional status of patients and make recommendations on the use of such standard instruments for payment purposes.

Section 546. GAO Report on Impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on Hospital Emergency Departments

GAO would be required to evaluate the impact of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and on-call physicians covering emergency departments and to submit a report to Congress by May 1, 2001.

Section 547. Clarification of Application of Temporary Payment Increases for 2001

The special increases and adjustments of the acute hospital payment update, the indirect medical education adjustment, and the disproportionate share hospital adjustment that are in effect between April and October 2001 do not apply to discharges after FY 2001 and are not included in determining subsequent payments.

Special update payments under the skilled nursing facility prospective payment system between April and October 2001 would not apply to SNF services furnished after that period and would not be included when determining payments for the subsequent period.

Special market basket update payments under the home health prospective payment system between April and October 2001 would not be included in determining subsequent payments. Also, temporary payments to certain rural home health agencies from April 1, 2001, through September 30, 2002, would not be included in determining subsequent payments.

TITLE VI - PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

SUBTITLE A - MEDICARE+CHOICE PAYMENT REFORMS

Section 601. Increase in Minimum Payment Amount

The provision would set the minimum payment amount for aged enrollees *within* the 50 states and the District of Columbia in a Metropolitan Statistical Area with a population of more than 250,000 at \$525 in 2001. For all other areas *within* the 50 States and the District of Columbia, the minimum would be \$475. For any area *outside* the 50 States and the District of Columbia, the \$525 and \$475 minimum amounts would also be applied, except that the 2001 minimum payment amount could not exceed 120% of the 2000 minimum payment amount. This increase would go into effect March 1, 2001.

Section 602. Increase in Minimum Percentage Increase

This provision would apply a 3% minimum update in 2001 and return to the current law minimum update of 2% thereafter. This increase would go into effect March 1, 2001.

Section 603. Phase in of Risk Adjustment

The current risk adjustment methodology (in which 10% of payments would be based on risk-adjusted inpatient data built on the 15 principal inpatient diagnostic cost groups (PIP-DCGs) and 90% would be adjusted solely using the older demographic method) would continue through 2003. Beginning in 2004, the risk adjustment would be based on data from inpatient hospital and ambulatory settings and the risk adjustment would be phased in at 30% for 2004, 50% for 2005, 75% for 2006, and 100% for 2007 and subsequent years.

Section 604. Transition to Revised Medicare+Choice Payment Rates

Within 2 weeks after the date of enactment of the Act, the Secretary must announce revised M+C capitation rates for 2001, due to changes from this Act. Plans that previously provided notice of their intention to terminate contracts or reduce their service area for 2001 would have 2 weeks after announcement of the revised rates to rescind their notice and submit ACR information. Further, any M+C organization that would receive higher capitation payments as a result of this Act must submit revised ACR information within 2 weeks after announcement of the revised rates. Plans may only reduce premiums, reduce cost sharing, enhance benefits, or utilize stabilization funds. Any regulations that limit stabilization fund amounts would be waived, with respect to ACR submissions under this section of the bill. Notwithstanding the issuance of revised rates, M+C organizations would continue to be paid on a fee-for-service basis for costs associated with new national coverage determinations that are made mid-year.

Section 605. Revision of Payment Rates for ESRD Patients Enrolled in Medicare+Choice Plans

This provision would require that the Secretary increase the M+C payment rates for enrollees with ESRD. The revised rates would reflect the demonstration rate (including the risk-adjustment methodology) of social health maintenance organizations' ESRD capitation demonstrations. The revised rates would include adjustments for factors such as renal treatment modality, age, and underlying cause of the disease. These revised rates would be effective beginning in January, 2002, and the Secretary of HHS would be required to publish the adjustments in final form by July 1, 2001.

Section 606. Permitting Premium Reductions as Additional Benefits under Medicare+Choice Plans

This provision would permit M+C plans to offer reduced Medicare Part B premiums to their enrollees as part of providing any required additional benefits or reduced cost-sharing. An M+C organization could elect a reduction in its M+C payment up to 125% of the annual Part B premium. However, only 80% of this amount could be used to reduce an enrollee's actual Part B premium. This would have the effect of returning up to 100% of the beneficiary's Part B premium. The reduction would apply uniformly to each enrollee of the M+C plan. Plans would include information about Part B premium reductions as part of the required information that is provided to enrollees for comparing plan options. This provision would be effective beginning in 2003.

Section 607. Full Implementation of Risk Adjustment for Congestive Heart Failure Enrollees for 2001

This provision would fully implement risk adjustment based on inpatient hospital diagnoses for an individual who had a qualifying congestive heart failure inpatient diagnosis between July 1, 1999 and June 30, 2000, if that individual was enrolled in a coordinated care plan offered on January 1, 2001. This would apply for only 1 year, beginning on January 1, 2001. This payment amount would be excluded from the determination of the budget neutrality factor.

Section 608. Expansion of Application of Medicare+Choice New Entry Bonus

This provision would expand the application of the new entry bonus for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans would be available January 1, 2001.

Section 609. Report on Inclusion of Certain Costs of The Department of Veterans Affairs and Military Facility Services in Calculating Medicare+Choice Payment Rates

The Secretary shall report to Congress by January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to Medicare-eligible beneficiaries in the calculation of an area's M+C capitation payment. This report would include, on a county-by-county basis: the actual or estimated costs of such services to Medicare-eligible beneficiaries; the change in M+C capitation payment rates if such costs were included in the calculation of payment rates; one or more proposals for the implementation of payment adjustments to M+C plans in counties where the payment rate has been affected due to failure to account for the cost of such services; and a system to ensure that when a M+C enrollee receives covered services through a facility of these Departments, there is an appropriate payment recovery to the Medicare program.

Subtitle B - Other Medicare+Choice Reforms

Section 611. Payments of Additional Amounts for New Benefits Covered During a Contract Term

The provision would require payment adjustments to M+C plans if a legislative change resulted in significant increased costs, similar to the current law requirements for adjusting payments due to significant increased costs resulting from National Coverage Determination (NCDs). In addition, this provision would require that cost projections and payment adjustments be based on actuarial estimates provided by the Chief Actuary of the Health Care Financing Administration.

Section 612. Restriction on Implementation of Significant New Regulatory Requirements Mid-Year

The provision would preclude the Secretary from implementing, other than at the beginning of a calendar year, regulations that impose new, significant regulatory requirements on M+C organizations.

Section 613. Timely Approval of Marketing Material That Follows Model Marketing Language

The provision would require the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization uses model language specified by the Secretary. This provision would apply to marketing material submitted on or after January 1, 2001.

Section 614. Avoiding Duplicative Regulation

This provision would further stipulate when Medicare law preempts State law or regulation from applying to M+C plans, by specifying that the term *benefit requirements* includes cost-sharing requirements. Second, the provision would stipulate that State laws and regulations affecting marketing materials, and summaries and schedules of benefits regarding an M+C plan, would also be preempted by Medicare law.

Section 615. Election of Uniform Local Coverage Policy For Medicare+Choice Plan Covering Multiple Localities

An M+C organization offering a plan in an area with more than one local coverage policy would be able to elect to have the local coverage policy for the part of the area that is most beneficial to M+C enrollees (as identified by the Secretary) apply to all M+C enrollees enrolled in the plan.

Section 616. Eliminating Health Disparities in Medicare+Choice Program

This provision would expand the M+C quality assurance programs for M+C plans to include a separate focus on racial and ethnic minorities. The Secretary would also be required to report to Congress how the quality assurance programs focus on racial and ethnic minorities, within 2 years after enactment and biennially thereafter.

Section 617. Medicare+Choice Program Compatibility with Employer or Union Group Health Plans

In order to make the M+C program compatible with employer or union group health plans, this provision would allow the Secretary to waive or modify requirements that hinder the design of, offering of, or enrollment in certain M+C plans. Plans included in the category are M+C plans under contract between M+C organizations and employers, labor organizations, or trustees of a fund established by employers and/or labor organizations.

Section 618. Special Medigap Enrollment Anti-Discrimination Provision for Certain Beneficiaries

This provision would extend the period for Medigap enrollment for certain M+C enrollees affected by termination of coverage. For individuals enrolled in an M+C plan during a 12-month trial period, their trial period would begin again if they re-enrolled in another M+C plan because of an involuntary termination. During this new trial period, they would retain their rights to enroll in a Medigap policy; however, the total time for a trial period could not exceed 2 years from the time they first enrolled in an M+C plan.

Section 619. Restoring Effective Date of Elections and Changes of Elections of Medicare+Choice Plans

This provision would allow individuals who enroll in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month, effective June 1, 2001.

Section 620. Permitting ESRD Beneficiaries to Enroll in Another Medicare+Choice Plan if the Plan in Which They are Enrolled is Terminated

This provision would permit ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area. This provision would also be retroactive, to include individuals whose enrollment in an M+C plan was terminated involuntarily on or after December 31, 1998.

Section 621. Providing Choice for Skilled Nursing Facility Services under the Medicare+Choice Program

Effective for M+C contracts entered into or renewed on or after the date of enactment, the provision would require an M+C plan to cover post-hospitalization skilled nursing care through an enrollee's "home skilled nursing facility" if the plan has a contract with the facility or if the home facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated SNFs that are under contract with the plan. A "home skilled nursing facility" is defined as (a) one in which the enrollee resided at the time of the hospital admission that triggered eligibility for SNF care upon discharge, or (b) is the facility that is providing such services through the continuing care retirement community in which the enrollee resided at the time of hospital admission, or (c) is the facility in which the spouse of the enrollee is residing at the time of the enrollee's hospital discharge. The beneficiary would be required to receive coverage for SNF care at the home facility that is no less favorable than he or she would receive otherwise in another SNF that has a contract with the plan.

Home skilled nursing facilities are permitted to refuse to accept Medicare+Choice enrollees or to impose conditions on their acceptance of such an enrollee.

The provision would require the Medicare Payment Advisory Commission (MedPAC) to analyze and, within 2 years of enactment, report to Congress on the effects of this provision on the scope of benefits, administrative and other costs incurred by M+C organizations, and the contractual relationships between those plans and SNFs.

Section 622. Providing for Accountability of Medicare+Choice Plans

The provision would mandate review of ACR submissions by the HCFA Chief Actuary with respect to submissions for ACRs filed on or after May 1, 2001.

Section 623. Increased Civil Money Penalties for Medicare+Choice Organizations That Terminate Contracts Mid-Year

The provision would increase to \$100,000 (or such higher level as the Secretary of Health and Human Services) the maximum civil money penalty that could be imposed for a Medicare+Choice organization that terminates its Medicare+Choice contract, other than at an appropriate time after providing appropriate notice.

SUBTITLE C - OTHER MANAGED CARE REFORMS

Section 631. 1-Year Extension of Social Health Maintenance Organization (SHMO) Demonstration Project

The provision would extend SHMO waivers until 30 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under the M+C program. This 30-month extension would supersede the 18-month extension in BBRA 99.

Section 632. Revised Terms and Conditions for Extension of Medicare Community Nursing Organization (CNO) Demonstration Project

Executive as it enacted with DSH, the provision would eliminate the requirement that CFC capitated payments be reduced to ensure budget neutrality. Through December 2001, the projects would operate under the same terms and conditions applicable during 1999, but with modification to the capitation rates. From October 1, 2000, through December 31, 2000, the capitation rates would be adjusted for inflation since 1999 and for changes in service packages, but reduced by 10 percent for in projects in Arizona, Minnesota, and Illinois and by 15 percent in New York. In 2001, the rates would be determined by actuarially adjusting the rates in the prior period for inflation, utilization, and changes to the service package. Adjustments would be made to case management fees for certain frail enrollees, and requirements would be imposed to create greater uniformity in clinical features among participating sites and to improve quality and enrollee satisfaction.

By July 1, 2001, the Secretary would be required to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance a report evaluating the projects for the period July 1997 through December 1999 and for the extension period after September 30, 2000. A final report would be required by July 1, 2002. The provision would require certain methods to be used to compare spending per beneficiary under the projects.

Section 633. Extension of Medicare Municipal Health Services Demonstration Projects

The provision would extend the Medicare municipal health services demonstration projects for 2 additional years, through December 31, 2004.

Section 634. Service Area Expansion for Medicare Cost Contracts During Transition Period

This provision would allow service area expansion for Medicare cost contracts, if the request was submitted to the Secretary before September 1, 2003.

TITLE VII - MEDICAID

Section 701. DSH Payments

(a) Modifications to DSH Allotments

For FY2001, the provision would set each state's DSH allotment equal to its allotment for FY2000 increased by the percentage change in the consumer price index for that year, subject to a ceiling that would be equal to 12% of that state's total medical assistance payments in that year.

For FY2002, the provision would set each state's DSH allotment equal to its allotment for 2001 as determined above, increased by the percentage change in the consumer price index for FY2001, subject to a ceiling equal to 12% of that state's total medical assistance payments in that year.

For extremely low DSH states, states whose FY1999 federal and state DSH expenditures (as reported to HCFA on August 31, 2000) are greater than zero but less than one percent of the state's total medical assistance expenditures during that fiscal year, the DSH allotments for FY2001 would be equal to 1 percent of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the consumer price index for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.

Effective on the date that the final regulation for Medicaid upper payment limits is published in the Federal Register.

(b) Assuring Identification of Medicaid Managed Care Patients

Effective for Medicaid managed care contracts in effect on January 1, 2001, the provision would clarify that Medicaid enrollees of managed care organizations and primary care case management organizations are to be included for the purposes of calculating the Medicaid inpatient utilization rate and the low_income utilization rate. Also effective January 1, 2001, states must include in their MCO contracts information that allows the state to determine which hospital services are provided to Medicaid beneficiaries through managed care, and would also require states to include a sponsorship code for the managed care entity on the Medicaid beneficiary's identification card.

(c) Application of Medicaid DSH Transition Rule to Public Hospitals in all States

The provision would revise BBA97, as modified by BBRA 99, so that the 175% hospital-specific DSH limit would apply to qualifying public hospitals in all states. (The limit currently applies only to certain public hospitals in California.) The limit, allowing DSH payments of up to 175% of each hospital's cost of unreimbursed care, would apply for two state fiscal years beginning on the first day of the state fiscal year that begins after September 30, 2002, and ends on the last day of the succeeding state fiscal year. Hospitals that would qualify for the higher hospital_specific limit would be those owned or operated by a state and meet the minimum federal requirements for disproportionate share hospitals. The permanent ceiling for California would not be affected.

For states operating under waivers approved under section 1115 of the Social Security Act, increased payments for public hospitals under this provision would be included in the baseline expenditure limit for the purposes of determining budget neutrality.

(d) Assistance for Certain Public Hospitals

The provision would provide additional funds for certain public hospitals that are: owned or operated by a state (or by an instrumentality or unit of government within a state); are not receiving DSH payments as of October 1, 2000; and have a low-income utilization rate in excess of 65% as of the same date. Funds provided under this section to states with eligible hospitals are in addition to DSH allotments. The total assistance under this section for all states cannot exceed the following amounts: \$15 million for FY2002; \$176 million for 2003; \$269 million for 2004; \$330 million for 2005; and for FY2006 and each fiscal year thereafter; \$375 million.

(e) DSH Payment Accountability Standards

The provision would require the Secretary to implement accountability standards to ensure that DSH payments are used to reimburse States and hospitals that are eligible for such payments and are otherwise in accordance with Medicaid statutory requirements.

Section 702. New Prospective Payment System for Federally-Qualified Health Centers and Rural Health Clinics

The provision would create a new Medicaid prospective payment system for federally qualified health centers (FQHCs) and rural health centers (RHCs) beginning in January of FY2001. Existing FQHCs and RHCs would be paid per visit payments equal to 100% of the average costs incurred during 1999 and 2000 adjusted to take into account any increase or decrease in the scope of services furnished. For entities first qualifying as FQHCs or RHCs after 2000, the per visit payments would begin in the first year that the center or clinic attains qualification and would be based on 100% of the costs incurred during that year based on the rates established for similar centers or clinics with similar caseloads in the same or adjacent geographic area. In the absence of such similar centers or clinics, the methodology would be based on that used for developing rates for established FQHCs or RHCs or such methodology or reasonable specifications as established by the Secretary. For each fiscal year thereafter, per visit payments for all FQHCs and RHCs would be equal to amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and adjusted for any increase or decrease in the scope of services furnished during that fiscal year. In managed care contracts, States must make supplemental payments to the center or clinic that would be equal to the difference between contracted amounts and the cost-based amounts. Those payments would be paid on a schedule mutually

agreed to by the State and the FQHC or RHC. Alternative payment methods would be permitted only when payments are at least equal to amounts otherwise provided.

The provision would also direct the Comptroller General to provide for a study on how to rebase or refine cost payment methods for the services of FQHCs and RHCs. The report would be due to Congress no later than 4 years after the date of enactment.

Section 703. Streamlined Approval of Continued State-Wide 1115 Medicaid Waivers

The provision would define the process for submitting requests for and receiving extensions of Medicaid demonstration waivers authorized under Section 1115 of the Social Security Act that have already received initial 3-year extensions. It would require each state requesting such an extension to submit an application at least 120 days prior to the expiration date of the existing waiver. No later than 45 days after the Secretary receives such application, the Secretary would be required to notify the State if she intends to review the existing terms and conditions of the project and would inform the State of proposed changes in the terms and conditions of the waiver. If the Secretary fails to provide such notification, the request would be deemed approved. During the 30-day period beginning after the Secretary provides the proposed terms and conditions to the state, those terms and conditions would be negotiated. No later than 120 days after the date that the request for extension was submitted (or such later date as agreed to by the chief executive officer of the State) the Secretary would be required to approve the application subject to the agreed upon terms and conditions or, in the absence of an agreement, such terms and conditions that are determined by the Secretary to be reasonably consistent with the overall objective of the waiver, or disapprove the application. If the waiver is not approved or disapproved during this period, the request would be deemed approved in the terms and conditions as have been agreed to (if any) by the Secretary and the State. Approvals would be for periods not to exceed 3 years and would be subject to the final reporting and evaluation requirements in current law.

Section 704. Medicaid County-Organized Health Systems

The provision would allow the current exemption for certain Health Insuring Organizations (HIOs) from certain Medicaid HMO contracting requirements to apply as long as no more than 14% of all Medicaid beneficiaries in the state are enrolled in those HIOs. This provision would be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Section 705. Deadline for Issuance Of Final Regulation Relating to Medicaid Upper Payment Limits

The provision would require the Secretary to issue final regulations governing upper payment limits (UPLs) for inpatient and outpatient services provided by certain types of facilities no later than December 31, 2000. It would also require that the final regulation establish a separate UPL for non-state-owned or operated government facilities based on a proposed rule announced in October, 2000.

The proposed rule would specify two transition periods for states with payment arrangements that are noncompliant, one for states with such arrangements effective on or after October 1, 1999 and the other for those states with arrangements that were effective before that date. The starting point for the phase-out of existing payment arrangements, the percentage reduction in payments each year, and the overall length of time permitted for full phase-out would vary for the two transition periods.

The provision also requires the final regulation to stipulate a third set of rules governing the transition period for certain states. This additional set of rules would apply to states with payment arrangements approved or in effect on or before October 1, 1992, or under which claims for federal matching were paid on or before that date, and for which such payments exceed the UPLs established under the final regulation. For these states, a 6-year transition period would apply, beginning with the period that begins on the first state fiscal year that starts after September 30, 2002 and ends on September 30, 2008. For each year during the transition period, applicable states must reduce excess payments by 15%. Full compliance with final regulations is required by October 1, 2008.

Section 706. Alaska FMAP

The provision would change the formula for calculating the state percentage and thus the federal matching percentage for Alaska for fiscal years 2001 through 2005. The state percentage for Alaska would be calculated by using an adjusted per capita income calculation instead of the state-wide average per capita income calculation generally used. The adjusted per capita income for Alaska would be calculated as the three year average per capita income for the state divided by 1.05.

Section 707. 1-Year Extension of Welfare-to-Work Transition

This provision extends by 1 year the sunset on transitional medical assistance for families no longer eligible for welfare from September 30, 2001 to September 30, 2002.

Section 708. Additional Entities Qualified to Determine Medicaid Presumptive Eligibility for Low-Income Children

Under Medicaid presumptive eligibility rules, States are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made.

The provision adds several entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children. These new entities include agencies that determine eligibility for Medicaid or the State Children's Health Insurance Program; or certain elementary and secondary schools, including those operated or supported by the Bureau of Indian Affairs.

Section 709. Development of Uniform QMB/SLMB Application Form

This provision requires the Secretary of Health and Human Services to develop a simplified national application form for States, at their option, to use for individuals who apply for medical assistance for medicare cost-sharing under the medicaid program.

Section 710. Technical Corrections

This provision makes technical medicaid amendments that exempt from certain upper income limitations individuals made eligible for medical assistance, at a State's option, under the Foster Care Independence Act of 1999 and under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

TITLE VIII - STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Section 801. Special Rule for Redistribution and Availability of Unused Fiscal Year 1998 and 1999 SCHIP Allotments

The provision would establish a new method for distributing unspent FY1998 and FY1999 allotments. States that use all their SCHIP allotments (for each of those years) would receive an amount equal to estimated spending in excess of their original exhausted allotment. Each territory that spends its original allotment would receive an amount that bears the same ratio to 1.05% of the total amount available for redistribution as the ratio of its original allotment to the total allotment for all territories.

States that do *not* use all their SCHIP allotment would receive an amount equal to the total amount of unspent funds, less amounts distributed to states that fully exhausted their original allotments, multiplied by the ratio of a state's unspent original allotment to the total amount of unspent funds. States may use up to 10% of the retained FY1998 funds for outreach activities.

To calculate the amounts available for redistribution in each formula described above, the Secretary would use amounts reported by states not later than December 15, 2000 for the FY1998 redistribution and November 30, 2001 for the FY1999 redistribution as reported on HCFA Form 64 or HCFA Form 21, as approved by the Secretary. Redistributed funds would be available through the end of FY2002.

Section 802. Authority to Pay Medicaid Expansion SCHIP Costs from Title XXI Appropriation

This provision provides a technical accounting clarification requested by the Health Care Financing Administration. It would authorize the payment of the costs of SCHIP Medicaid expansions and costs of benefits provided during periods of presumptive eligibility from the SCHIP appropriation rather than from the Medicaid appropriation, with a subsequent offset. In addition, the provision would codify proposed rules regarding the order of payments for benefits and administrative costs from state-specific SCHIP allotments.

Section 803. Application of Medicaid Child Presumptive Eligibility Provisions

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. There is no express provision for presumptive eligibility under separate (non-Medicaid) SCHIP programs. However, the Secretary of HHS permits states to develop, for separate (non-Medicaid) SCHIP programs, procedures that are similar to those permitted under Medicaid.

The provision clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

TITLE IX - OTHER PROVISIONS

SUBTITLE A - PACE PROGRAM

Section 901. Extension of Transition for Current Waivers

The provision would permit the Secretary to continue to operate the Program of All-Inclusive Care for the Elderly (PACE) under waivers for a period of 36 months (rather than 24 months), and States may do so for 4 years (rather than 3 years). OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. BBA 97 established PACE as a permanent provider under Medicare and as a special benefit under Medicaid.

Section 902. Continuing of Certain Operating Arrangements Permitted

If prior to becoming a permanent component of Medicare, a PACE demonstration project had contractual or other operating arrangements that are not recognized under permanent program regulations, the provision would require the Secretary, in consultation with the state agency, to permit it to continue under such arrangements as long as it is consistent with the objectives of the PACE program.

Section 903. Flexibility in Exercising Waiver Authority

The provision would enable the Secretary to exercise authority to modify or waive Medicare or Medicaid requirements to respond to the needs of PACE programs related to employment and the use of community care physicians. The Secretary must approve requests for such waivers within 90 days of the date the request for waiver is received.

SUBTITLE B - OUTREACH TO ELIGIBLE LOW-INCOME MEDICARE BENEFICIARIES

Section 911. Outreach on Availability of Medicare Cost-Sharing Assistance to Eligible Low-income Medicare Beneficiaries

The provision would require the Commissioner of the Social Security Administration to conduct outreach efforts to identify individuals who may be eligible for Medicaid payment of Medicare cost sharing and to notify these persons of the availability of such assistance. The Commissioner would also be required to furnish, at least annually, a list of such individuals who reside in each state to that state's agency responsible for administering the Medicaid program as well as to any other appropriate state agency. The list should include the name and address, and whether such individuals have experienced reductions in Social Security benefits. The provision would also require the General Accounting Office to conduct a study of the impact of the outreach activities of the Commissioner to submit to Congress no later than 18 months after such outreach begins. The provision would be effective one year after date of enactment.

SUBTITLE C - MATERNAL AND CHILD HEALTH BLOCK GRANT

Section 921. Increase in Authorization of Appropriations for the Maternal and Child Health Services Block Grant

The provision would increase the authorization of appropriations for the Maternal and Child Health Services Block Grant under Title V from \$705,000,000 to \$850,000,000 for fiscal year 2001 and each fiscal year thereafter.

SUBTITLE D - DIABETES

Section 931. Increase in Appropriations for Special Diabetes Programs for Type I Diabetes and Indians

The provision would extend for 1 year, to FY2003, the authority for grants to be made for both the Special Diabetes Program for Type I Diabetes and for the Special Diabetes Programs for Indians under the Public Health Service Act. The provision would also expand funding available for these programs. For each grant program, the provision would increase total funding to \$100 million each for FY2001, FY2002 and FY2003. For FY2001 and FY2002, \$30 million of the \$100 million for each program would be transferred from SCHIP as set forth in the Balanced Budget Act of 1997; the remaining \$70 million would be drawn from the Treasury out of funds not otherwise appropriated. In FY2003, the entire \$100 million would be drawn from the Treasury out of funds not otherwise appropriated. In addition, the provision would extend the due date on final evaluation reports for these two grant programs from January 1, 2002 to January 1, 2003.

Section 932. Appropriations for Ricky Ray Hemophilia Relief Fund

This provision provides for a direct appropriation of \$475 million for FY2001. Funds would be available until expended.

SUBTITLE E – INFORMATION ON NURSING FACILITY STAFFING

Section 941. Posting of Information on Nursing Facility Staffing

The provision would require medicare skilled nursing facilities and medicaid nursing facilities to post nurse staffing information daily for each shift in the facility, effective January 1, 2003.

SUBTITLE F – ADJUSTMENT OF MULTIEMPLOYER PLAN BENEFITS GUARANTEED

Section 951. Adjustment of Multiemployer Plan Benefits Guaranteed

The provision adjusts the level of multiemployer pension plan benefits guaranteed under title IV of ERISA.

SUBTITLE G – NATIONAL INSTITUTE OF BIOMEDICAL IMAGING AND BIOENGINEERING

Section 961. National Institute of Biomedical Imaging and Bioengineering

The provision establishes a National Institute of Biomedical Imaging and Bioengineering with the National Institutes of Health.